

Wisconsin Department of Regulation & Licensing

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BOARD OF NURSING

CERTIFICATION FORM FOR MALPRACTICE INSURANCE COVERAGE FOR NURSE-MIDWIFE

(Complete all that apply)

Name: _____

Address: _____

Application ID # (if applies): _____

MAKING A FALSE STATEMENT IN CONNECTION WITH ANY APPLICATION FOR CREDENTIAL IS GROUNDS FOR REVOCATION OR DENIAL.

Please certify which of the following applies to you by checking the appropriate box and signing and dating this form. Please return this form with your completed application (Form #407).

- ☐ I hereby certify that I have malpractice liability insurance coverage in the amount specified in s. 655.23(4), Stats.
- ☐ I am not required to have malpractice insurance coverage because (check one):
- ☐ I am a federal, state, county, city, village, or town employee who practices nurse-midwifery within the scope of my employment.
 - ☐ I am an employee of the federal public health service under 42 U.S.C. s. 233(g).
 - ☐ My employer has in effect malpractice liability insurance that provides coverage for me in the amount that is at least the minimum amount specified in s. 655.23(4), Stats.
 - ☐ I do not provide care for patients at this time, but I understand I must have malpractice liability insurance coverage in the amount specified in s. 655.23(4), Stats. prior to beginning patient care.

Date: _____

Signature: _____